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for a thriving Kansas*



**Joint Committee on Information Technology
Barb Langner
Kansas Access to Comprehensive Health Program
December 15, 2009**

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KATCH Project Summary (HRSA Grant)

On September 1, 2009, KHPA was awarded a grant by the Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services. KHPA applied for HRSA's State Health Access Program (SHAP) grant that sought to support states that were expanding or starting programs that would provide insurance for the uninsured. Based on Kansas' recent commitment to expand the Children's Health Insurance Program (CHIP) to the 2008 250% FPL, KHPA asked for the grant in order to fund additional outreach and a new eligibility system. HRSA awarded KHPA the amount requested for the first year, \$1,930,490, and recommended subsequent grant awards (KHPA must apply for continuing grants each year, but these grants are non-competitive) also in the amounts originally requested for the following four years--\$9,432,124; \$9,635,813; \$9,488,919; and \$9,832,096 respectively—for a total grant award of \$40,319,442. Of that amount, \$28,837,500 is budgeted for the procurement of a medical program eligibility system. The State is expected to match the grant amounts by 20 per cent. A contribution of \$200,000 by the Kansas Health Foundation and in kind contributions of staff salaries for the existing KHPA staff who will be working on the project and their related expenses meet the matching requirement for year one. In addition to the in kind contribution by KHPA, the money appropriated by the Kansas Legislature for the expanded CHIP population is used to meet the matching requirement in subsequent years. No additional money is being requested for matching the grant amounts.

The Kansas Access to Comprehensive Health (KATCH) project includes the expansion of health insurance coverage to children below 250% of FPL under the current Children's Health Insurance Program (CHIP). Money has been appropriated by the state legislature to fund the administrative costs of additional application processing and to fund the cost of coverage. However, critical infrastructure investments to support any expansion of coverage are long overdue. Kansas currently is dependent on a mainframe based eligibility system that was implemented 22 years ago and no longer supports public medical programs as they have evolved. Simple policy changes or expansions of existing programs require nearly a year to implement and require significant manual work-arounds. Some public insurance programs require determinations to be done off the system (e.g., paper, spreadsheets) and then the system has to be "tricked" to actually enroll eligible beneficiaries. This introduces error, reduces efficiency, and has made it impossible to acquire and track data to analyze eligible and enrolled populations. The limitations of the system also prevent designing new insurance programs that are not based on the linkage between welfare and health care that remain infused into the current eligibility system. This key piece of antiquated infrastructure makes it very difficult to cover new groups of people, and is a barrier to efficient and effective enrollment.

The KATCH project is based on Kansas' most recent investment in health care reform, which is the expansion of coverage to uninsured children of working families. The system that is envisioned will certainly benefit other populations, but the initial target is the expansion population along with other currently eligible but unenrolled children and pregnant women. As is the case in many states, Kansas has a significant number of children who we believe currently meet the guidelines for coverage in CHIP or Medicaid, but remain unenrolled and uninsured. In addition, low income women tend not to enroll in public health insurance until later in their pregnancies, reducing the effectiveness of prenatal care. More detail on this is explained in the narrative submitted with our grant application.

We believe that there are two primary barriers that keep eligible, uninsured individuals from enrolling. First, KHPA believes that the mail-in process created when CHIP was initially implemented in 1999 is an extremely efficient model for managing "low-touch" (more self-sufficient) families; however, some families require more personal involvement, follow-up, and interaction. That interaction must occur in places where they are already likely to be. The second barrier really springs from the first. Kansas does not have the modern technology required to be in the locations where uninsured people present themselves and to do the follow-up information gathering necessary to enroll uninsured, hard-to-reach populations. KHPA estimates that approximately 20,000 uninsured children are currently eligible and 9,000 additional uninsured children will be eligible under the expansion. New programs like these are far less effective without the systems required to enroll people into those programs. Expansions such as those under consideration in Federal health reform proposals would be impossible without a new system.

Our current enrollment model allows people to access the program in two ways. People can choose to go to an SRS office to fill out a paper application or they can obtain one by calling a toll free number, complete it, and mail it in. (See Figure 1). The

Department of Social and Rehabilitation Services (SRS) is the state's human services agency and is separate from KHPA, but does Medicaid and CHIP determinations on behalf of KHPA. SRS used to have an office in all 105 Kansas counties, but reduced

Current Model

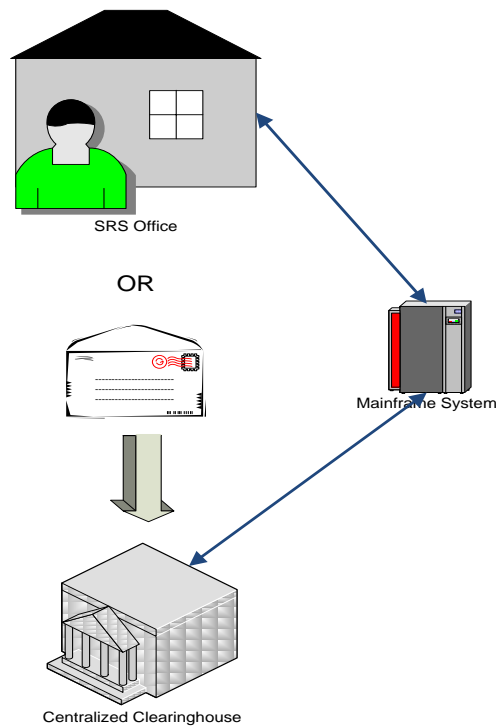


Figure 1

that number to around 60 approximately six years ago. SRS established “access points” in communities so that people could obtain information and applications for different types of assistance within their communities, but the local presence of the SRS office has disappeared from many counties. Kansas is diverse ranging from the major metropolitan Kansas City area on the border with Missouri to the frontier regions of western Kansas and literally every kind of community in between. Many people in western Kansas now have to travel long distances to get to an SRS office. Toll free numbers have been established, which work well for some people (doing business via mail and over the phone) but not well for others. Much of the burden of seeking out assistance with medical coverage has been shifted to the individual in need, reaching out to an SRS office or KHPA’s centralized enrollment process.

KHPA’s enrollment model also needs to focus on some smaller sub-populations within Kansas that are hard to reach, such as Native American populations. There are several reservations in different parts of Kansas. Evidence suggests that some of these sub-populations are under-represented in terms of enrollment, while the proportion of those sub-populations who are eligible tends to be higher.

KHPA’s vision for effective outreach and enrollment calls for a greater presence “on the ground” in clinics, with community resource partners, in tribal settings, and in other public venues where enrollment can occur with varying levels of assistance. The KATCH project includes funding for 12 out stationed workers and a supervisor. The out stationed eligibility workers will be placed in locations around the state, such as community health clinics, where the uninsured go to receive care. They will be able to do eligibility determinations on site. KHPA’s vision is that these workers would also be able to perform outreach activities in the surrounding areas and to do full eligibility determinations at those locations.

KHPA’s vision for effective outreach and enrollment is to leverage community involvement with minimal public investment. A key component of the KATCH project is to enlist community partners who routinely work with the uninsured and have them assist individuals in filing applications for assistance. The grant includes funding for three outreach trainers who will work to develop this network of community partners and train them on how to assist with properly completing applications and acquiring the necessary documentation and verification.

To further leverage limited state resources, KHPA plans on expanding our network of presumptive eligibility sites. Presumptive eligibility allows non-state staff, such as the staff of a clinic, to do an initial “presumptive” determination of eligibility for children and pregnant women in order to begin providing coverage right away. This must be followed up with a full determination, however, to maintain Federal matching funds for these expenses. There currently are four presumptive eligibility sites, but there is no online presumptive eligibility screening tool to effectively allow for consistent application of rules by clinical staff and the presumptive determination still has to be followed up with a paper application. This makes expanding presumptive eligibility with our current resources infeasible.

KHPA also plans on placing computer and scanning equipment in up to 250 public locations around the state such as libraries, places of worship, or other locations where the proprietors are interested in allowing people to apply from their location. At these locations a kiosk or workstation will support people in filling out an online application and scanning the necessary verification in order to submit a complete application all at once.

Finally, for those who have access to the Internet in their own homes or the homes of friends or family, the online application will be available for them to submit an application online. If they can scan documents at home, they can e-mail them in, or if they can go to one of the public locations and scan them in there. None of this replaces the current model, but supplements the current paper-based model. People can still use the mail-in process or can still go through their local SRS office. The hope is, however, people will use electronic means more and more.

All of these things are to address the first barrier—having more local contacts so that KHPA can go where uninsured people are and enroll them in public health programs. This leads to the second barrier—the technology to actually accomplish this.

In order to make significant strides in enrolling children who are already eligible and pregnant women earlier in their pregnancy, as well as reaching the estimated 9,000 additional children anticipated under this expansion, KHPA requested \$28,837,500 over the five years of the grant in order to obtain a web based eligibility system that includes the online application and the presumptive eligibility screening tool. This amount is an estimate based on preliminary work KHPA has done over the past two years investigating the types of systems available, what other states are doing, and what is on the horizon. KHPA’s vision is that we will procure a system that will meet KHPA’s current and future needs for access and program flexibility (See figure 2).

New Model

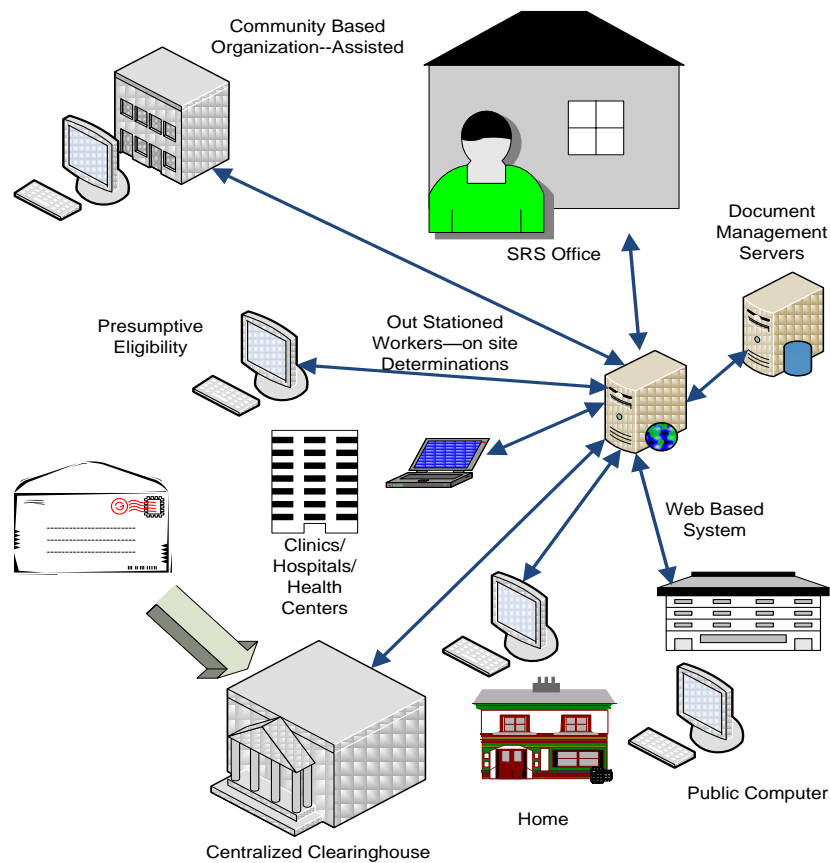


Figure 2

KHPA envisions a service oriented architecture (SOA) based system that is modular and flexible, allowing for easy adaptation and reuse as well as data sharing with other entities and systems. The system will necessarily be rules driven in order to accommodate quick policy and program changes to the highly complex set of Medicaid eligibility criteria. The rules engine also shifts the burden from the current reliance on an experienced, extremely knowledgeable workforce to implement and apply policy accurately, consistently, and equitably to the system itself. Workers will still need to be knowledgeable, but the learning curve will not be so steep and program success will not be nearly as dependent on people.

A workflow engine will be incorporated in order to allow for efficient processing of applications and case maintenance tasks. Tasks can be assigned to different people who may be located many miles apart. Location of those doing the work will be much less important now than it has been in the past. In addition, the system will need to hook into KHPA's document management system, ImageNow, via open application programming interfaces (APIs). This allows for a "paperless" processing system. Any paper that comes through the door stays at the door. Once the paper documents are imaged, the document management system allows for the documents to be accessed by multiple people at the same time and to not have to wait for retrieval of a file from the file room. It also extends the reach of a field worker or Clearinghouse worker as all those with access to the system will be able to see the appropriate files regardless of their locations.

An online application allows for the application data to be delivered in an electronic format, eliminating redundant data entry. The electronic record this creates becomes the case from which eligibility is determined and is linked to the relevant imaged documents. Again, location is much less important because the web based eligibility system will allow secure access from a desktop PC or a laptop accessing the Internet via a wireless air card or Wi-Fi. Naturally, security will be a high priority in order to protect the transmission and sharing of this extremely sensitive data. However, none of the data need be resident on a PC or laptop. A virtual desktop can be utilized for remote access and all processing occurs on servers in a central location.

Supplementing the online application is the presumptive eligibility tool. This is the online application plus a screening tool authorized to be used in certain locations that will produce a temporary eligibility record and allow for immediate coverage of services. By incorporating this into the online application, families do not have to fill out a paper application in addition to providing information during the presumptive eligibility process.

All of the technology described leverages KHPA's limited resources to expand outreach and enroll the uninsured. Without this investment in technology, effective outreach cannot occur. The current technology will allow KHPA to have out stationed workers in other locations, but they will not be able to travel from the workstation in their office to do additional determinations. The system KHPA currently uses does not support the varied eligibility rules for our current programs and requires many manual workarounds. This antiquated system does not allow for the expansion of presumptive eligibility or community based enrollment. It does not include, nor could it support, an online application that makes applications more user-friendly, requires less expertise and training to navigate, and creates an electronic case record automatically.

To sum up, the new technology serves as a key building block for a strategy that leverages community resources and individual initiative to eliminate barriers between eligibility and enrollment. With full funding for both the technology and other resources needed to connect with community resources and individual applicants, the grant enables KHPA to make substantial progress in achieving its vision for effective and efficient enrollment in public insurance programs.